APPLICATION FOR: GRACE REHABILITATION AND HEALTH CENTER

31 NORTH PARK AVENUE
MEADVILLE, PA 16335

Please return to Admissions Coordinator

INDIVIDUAL DATA

Full Name of Applicant ______________________________ Maiden Name ____________

Mailing Address ______________________________ Phone ( ) ____________

______________________________ Zip Code ____________

Is Applicant a U. S. Citizen? ☐ Yes ☐ No

Age ______ Sex _____ Date of Birth ____________ Birthplace ______________________

Status: ☐ Married - Date ____________ ☐ Single ☐ Widowed ☐ Divorced

Former Occupation ____

Spouse ______________________________ Maiden Name ____________

Address ______________________________ Phone ( ) ____________

If Deceased, Date of Death ____________ Power of Attorney (POA) ☐ Yes ☐ No

Name of POA ______________________________ Phone ( ) ____________

Person (Responsible Party) to be notified in case of emergency ______________________

Address ______________________________ Home Phone ( ) ____________

______________________________ Work Phone ( ) ____________

Do you have Advance Directives? ☐ Yes ☐ No ☐ Living Will ☐ Do Not Resuscitate ☐ Durable POA

Physician ______________________________ Phone ( ) ____________

Address ____

Dentist ______________________________ Phone ( ) ____________

Address ____

Podiatrist ______________________________ Phone ( ) ____________

Address ____

Attorney ______________________________ Phone ( ) ____________

Address ____

Ambulance Membership ? ☐ Yes ☐ No Name of Company ______________________

Pre-paid Funeral? ☐ Yes ☐ No Funeral Home ______________________________

Address ______________________________ Phone ( ) __________

If no pre-arrangement, funeral home preference ______________________________

FAMILY DATA

Names, addresses and ages of nearest relatives who may be contacted:

1. Name ______________________________ Age _____ Relationship __________

Address ______________________________ Phone ( ) __________

2. Name ______________________________ Age _____ Relationship __________

Address ______________________________ Phone ( ) __________

3. Name ______________________________ Age _____ Relationship __________

Address ______________________________ Phone ( ) __________

* * * * * * * * * *

Father of Applicant ______________________________ Birthplace __________

Mother of Applicant ______________ Maiden Name __________ Birthplace __________

Father living? ☐ Yes ☐ No Mother living? ☐ Yes ☐ No

BIOGRAPHICAL AND SOCIAL DATA

Needs/Reason for entrance to facility ______________________________

Current family situation and living arrangements ______________________________

____

What are your special interests and hobbies? ______________________________

What do you enjoy? ______________________________ ☐ Music ☐ TV ☐ Cards ☐ Games

Fraternal, social or professional organizations in which you hold membership ______________

____

Are you a Veteran? ☐ Yes ☐ No Veteran's Spouse? ☐Yes ☐ No

VA Claim No. ______________

Religious affiliation ______________ Church ______________________________

Clergy ______________________________

Address ______________________________ Phone ( ) __________

Highest education level: ☐ Elementary ☐ High School ☐College and Beyond ☐Trade School

How did you hear about our facility? ______________________________

AGREEMENT AND AFFIRMATION

I understand and agree that before entering Wesbury United Methodist Retirement Community (hereinafter referred to as "Wesbury") my care needs can be evaluated by authorized personnel at the request of Wesbury.

I understand and agree that, upon admission to Wesbury, I will abide by all rules and regulations of Wesbury including any changes duly announced.

I agree that, upon entrance to Wesbury's Grace Rehabilitation and Health Center, I will secure the services of a physician who will meet the requirements set by federal and state regulations and by those policies adopted by the Board of Directors of Wesbury. This physician must be responsible for regularly scheduled visits and be available on emergency call, or will make provision for coverage in case of an emergency. In the event the attending physician fails to comply with the required visits, I agree that the Medical Director of Wesbury or his designee may and must visit me. Should I be unable to secure the services of a physician, I authorize Wesbury to secure a physician for me. I agree that the physician's care shall be provided at my expense.

I agree to pay the charges for room and care, nursing care, and special services monthly, the rates being subject to change upon a notice of one month in advance.

Should my account at any time become delinquent, I agree to an additional finance charge which will be assessed monthly until the account is in order.

I understand that all drugs, treatments and special services will be provided at my expense in addition to the regular charge of room and care.

After admission to Wesbury, should I require, or desire, special nursing care, I agree that it shall be provided at my expense and instruct the person responsible for my financial affairs to provide for this.

Should I require hospitalization, emergency care, consultation with another medical doctor, diagnostic studies or other treatment upon recommendation of my physician and/or Wesbury, and it is impossible to contact the person indicated as my responsible party, I authorize and agree that I shall be transferred to a hospital at my own expense. Should this require the use of an ambulance or other means of transportation, I agree that the expense will be billed directly to me.

I understand and agree that Wesbury is not responsible for replacing the loss of, or damage to, any of my personal property while I am a resident at Wesbury. Only those items properly identified and placed in the Nursing Center's depository for security purposes shall be the responsibility of Wesbury.

I understand that a discharge plan will be developed within seven days of admission and will be reviewed and updated on a timely basis while I am a resident at Wesbury.

I understand that when I am permanently discharged from the facility and a bed is no longer reserved for me whether due to death or transfer, my personal belongings will be stored in a storage area for a period not to exceed 30 days. If these items have not been removed within 30 days of the discharge date, they will be disposed of at the discretion of the facility.

Date ____________________________

____
Signature of Applicant

____
Witness

____
Signature of Responsible Party

Wesbury United Methodist Retirement Community is a retirement community governed by a 30 member Board of Directors and affiliated with the Western Pennsylvania Annual Conference of the United Methodist Church, which serves as the corporate body. Wesbury is organized as a not-for-profit corporation. Since the corporation is categorized 501(c)(3) by the Internal Revenue Service, contributions are tax deductible.

Monthly charges may change from time to time as costs increase and will always be the latest revised rate.

Wesbury reserves the right to reject any applicant for admission, without prejudice, unless the application is fully completed and necessary financial arrangements are made.

Changes in room assignments may be made anytime, at the discretion of the administration or nursing staff of Wesbury. The resident and/or responsible party shall be notified prior to any change in room assignments.

Rules and regulations of Wesbury may be changed at any time and, upon proper notification, all residents will be expected to abide by the changes. Special arrangements or exceptions to the rules and regulations will be granted only if, in the judgment of the administration, nursing and medical staff, they are in the best interest of all concerned.

AGREEMENT OF RESPONSIBLE PARTY

In consideration of the admission of ____ as a resident of Wesbury United Methodist Retirement Community, and the continued nursing services rendered as agreed upon, I will be responsible for the prompt payment of all charges made to the account of the applicant.

I have read the statements and conditions printed on the preceding pages of this application, and agree to be bound by the terms stated in the agreement. I will cooperate with the administration and the staff of Wesbury to the fullest extent.

I understand that this agreement will remain in full force until a written notice of its cancellation is authorized by me, or requested by Wesbury.

____
Signature of Responsible Party

Date ___________________________

____
Address

Phone (   ) ____________________

____

____
Witness

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